



City of Alexandria, Department of Recreation, Parks and Cultural Activities
Therapeutic Recreation Program
1108 Jefferson Street, Alexandria, VA 22314
Office: (703) 746-5422 Fax: (703) 535-5863



**Therapeutic Recreation Program
Summer Registration Packet**

The Amazing Race

“Let’s Get Connected”



Summer 2013
Connecting to Others Around the World!



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Summer Registration Form

Youth / Teen Programs

The City of Alexandria complies with the Americans with Disabilities Act for qualified individuals. To make an ADA accommodation request, please call (703) 746-5423 or email Jackie Person at jackie.person@alexandriava.gov. All ADA requests must be submitted four weeks prior to the start of the program.

(Please use a blue or black ball point pen)

Program(s): (Please check) ☐ Pre-School Camp (3 - 5 years old)
☐ Camp Kaleidoscope (6 - 14 years old)
☐ Camp Teen Scene (15 - 21 years old)

Participant's Name: _____

Is your child attending Summer School/ESY? ☐ Yes ☐ No If so, what are the dates: _____

Will your child need Before/After Care Services? _____ Before Care: _____ After Care: _____

Date of Birth: ____/____/____ Age: ____ Sex: ____ Previously Enrolled in TR Program ☐ Yes ☐ No

Home Address: _____
Street Apt. Number City/State Zip Code

Name of Parent/Guardian: _____ Name of Parent/Guardian: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

Social Worker/Case Manager Name: _____ Phone: _____

School Name/Teacher Name: _____ Phone: _____

*Name of Physician: _____ Phone: _____

*Medical Insurance: _____ *Policy Number: _____

*(Information is required)

Emergency Contact Names (other than persons living in your home) with authorization to care for and pick up the applicant in case of an emergency:

Name: _____ Name: _____

Phone: _____ Phone: _____

Other: _____ Other: _____

Relationship: _____ Relationship: _____

Emergency Treatment Release: I give permission, at my expense, for the Therapeutic Recreation Program to acquire emergency treatment for my child, if it is necessary.

Signature _____ Date _____

Photographic Release: I hereby ☐ Do ☐ Do Not grant permission for the Therapeutic Recreation Program to use individual and/or group photographs for publicity, education, and in any or all publications and other media.

Signature _____ Date _____

Liability Waiver: I, on behalf of my child, recognize that there are risks inherent to participating in program activities and agree to hold harmless the City of Alexandria Department of Recreation, its officers, employees, and volunteers from any and all claims from bodily injury and/or property damage which result from my child participation in any and all activities sponsored by the said Department.

Signature _____ Date _____

Transportation / Field Trip Release: I give permission for my child to be transported by the Therapeutic Recreation Program to and from all programs and activities.

Signature _____

Date _____

Swimming Release: I give permission for my child to participate in the Therapeutic Recreation Program swimming activities.

Signature _____

Date _____

Please Check the Primary Disability(Required Information)

<input type="checkbox"/> Mild MR	<input type="checkbox"/> Multiple Disabilities	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Moderate MR	<input type="checkbox"/> Specific Learning Disability	<input type="checkbox"/> Spinal Cord Injury
<input type="checkbox"/> Severe MR	<input type="checkbox"/> Other Orthopedic Impairment	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Pervasive Developmental Disorder	<input type="checkbox"/> Attention Deficit/Hyperactivity Disorder	<input type="checkbox"/> Autism
<input type="checkbox"/> Emotional Disturbance	<input type="checkbox"/> Visually Impaired	<input type="checkbox"/> Asperger's Disorder
<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Other

Any Other Pertinent Information: _____

Medical Information & Characteristics

• Allergies (food, bee stings, medications, etc.)	Yes _____ No _____
• Dietary Restrictions	Yes _____ No _____
• Physical Limitations / Restrictions	Yes _____ No _____
• Asthma	Yes _____ No _____
• Seizures (Please note frequency and type)	Yes _____ No _____
• Assistance needed for feeding and/or toileting	Yes _____ No _____
• Physically aggressive	Yes _____ No _____
• Unusual Fears	Yes _____ No _____
• Wanders away from group	Yes _____ No _____

Applicant **WILL** **WILL NOT** be taking medication during Therapeutic Recreation Program hours.

Medication: Dosage: _____

Time of day medication is to be administered: _____

Medication Release: I understand persons who administer medication or special procedures may be inexperienced and are medically untrained. Should the administration of medication be for more than 10 days during program hours, a Medication Release Form must be completed by both the physician and the parent/guardian. No medication will be administered including inhalers and Epipens; if the medication is not packaged in the original container with the prescription label and direction label attached.

I, _____ the parent/guardian of _____ hereby request that members of the Therapeutic Recreation staff be caretakers of my child's medication and administer any medication or procedures as prescribed by the physician.

Signature _____

Date _____

DEPARTMENT OF SOCIAL SERVICES COMMONWEALTH OF VIRGINIA
Standards for Licensed Child Day Centers
Parental Agreements

I, _____, understand that in the event I am notified by the Therapeutic Recreation Program that my child has become ill, I will make arrangements to have my child picked up within two hours if requested by the center; and

I, _____, understand that I must inform the center within 24 hours or the next business day after my child, or any member of my immediate household has developed any reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be reported immediately.

Signature _____

Date _____

Office Use Only:

Date Received: ____ / ____ / ____

All Paperwork Received: ____ / ____ / ____



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**Therapeutic Recreation Summer Camp
Registration Application**

Participant's Name: _____ Participant's Age: _____

____ Pre-School Camp (3 - 5 years old)	Min Enrollment: 6 and Max Enrollment: 12
____ Camp Kaleidoscope (6 - 14 years old)	Min Enrollment: 15 and Max Enrollment: 25
____ Camp Teen Scene (15 - 21 years old)	Min Enrollment: 10 and Max Enrollment: 15

Before and After Care Program – (Camp Kaleidoscope and Camp Teen Scene Only)

____ Before Care is from 8:30am – 9:30am	Min Enrollment: 6 and Max Enrollment: 12
____ After Care is from 4:00pm – 5:00pm	Min Enrollment: 6 and Max Enrollment: 12

I hereby apply for the sessions checked below: **Please use a blue or black ball point pen.**

Pre-School Camp (8:30am – 12:00pm)

____ July 1 – July 12 (\$ 50.00) ____ July 15 – July 26 (\$ 50.00)

Camp Kaleidoscope and Camp Teen Scene (9:30am – 4:00pm)

____ Jun 24 – July 5 (\$100.00) ____ July 8 – July 19 (\$100.00)
____ July 22 – Aug 2 (\$100.00)

- ☐ My child will be attending summer school this summer.
- ☐ My child will participate in the Extended School Year Program (ESY).
- ☐ My child will be receiving additional therapy sessions during summer camp hours.

Please Note: No program on Thursday, July 4, 2013.

The session fee covers the cost of the program. These fees are not pro-rated. **We ask that all session payments be made by cash or check. All checks should be made payable to the City of Alexandria, and in the memo section, please write Therapeutic Recreation Program.** Please Note: There are additional fees for field trips and special activities. Receipts will be given for all payments received for your records.

***Check Negotiability:** The customer's name, address and phone number must be pre-printed on the check and the check number must be **300** or greater.

I, _____ understand that the cost for the sessions are due by the first day of each session. All payments must be sealed in an envelope with my child's name on it.

I, _____ understand that checks returned for insufficient funds will be assessed a \$35.00 fee by the City of Alexandria.

Signature: _____ Date: _____
Parent/Guardian



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Program Outline



Pre-School Camp

Monday, July 1, 2013 - Friday, July 26, 2013

Time: 8:30am - 12:00pm

Ages: 3 - 5

Session	Dates	Cost	Due Date
Session 1	July 1 - July 12	\$50.00	July 1
Session 2	July 15 - July 26	\$50.00	July 15

Camp Kaleidoscope and Camp Teen Scene

Monday, June 24, 2013 - Friday, August 2, 2013

Time: 9:30am - 4:00pm

Ages: 6 - 14 and 15 - 21

Session	Dates	Cost	Due Date
Session 1	June 24 - July 5	\$100.00	June 24
Session 2	July 8 - July 19	\$100.00	July 8
Session 3	July 22 - August 2	\$100.00	July 22

NO PROGRAM JULY 4TH



Before and After Care services are available upon request. Please contact the Therapeutic Recreation office for more information. TR Program Office: 703-746-5424.